

STATE OF ILLINOIS

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Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>90</u>	Skilled (SNF)	<u>90</u>	<u>32850</u>	1
2	<u>0</u>	Skilled Pediatric (SNF/PED)	<u>0</u>	<u>0</u>	2
3	<u>0</u>	Intermediate (ICF)	<u>0</u>	<u>0</u>	3
4	<u>0</u>	Intermediate/DD	<u>0</u>	<u>0</u>	4
5	<u>0</u>	Sheltered Care (SC)	<u>0</u>	<u>0</u>	5
6	<u>0</u>	ICF/DD 16 or Less	<u>0</u>	<u>0</u>	6
7	<u>90</u>	TOTALS	<u>90</u>	<u>32,850</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Public Aid Recipient	3 Private Pay	4 Other	5 Total	
Patient Days by Level of Care and Primary Source of Payment						
8	SNF	<u>15840</u>	<u>3195</u>	<u>1234</u>	<u>20,269</u>	8
9	SNF/PED	<u>0</u>	<u>0</u>	<u>0</u>		9
10	ICF	<u>0</u>	<u>0</u>	<u>0</u>		10
11	ICF/DD	<u>0</u>	<u>0</u>	<u>0</u>		11
12	SC	<u>0</u>	<u>0</u>	<u>0</u>		12
13	DD 16 OR LESS	<u>0</u>	<u>0</u>	<u>0</u>		13
14	TOTALS	<u>15,840</u>	<u>3,195</u>	<u>1,234</u>	<u>20,269</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 61.70%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A - None

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/7/1998

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/7/1998 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number of beds certified 14 and days of care provided 1,234Medicare Intermediary TRAILBLAZER HEALTH ENTERPRISES, LLC

IV. ACCOUNTING BASIS

ACCURAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number

ALDERWOOD HEALTH CARE CENTER

0043489

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	104,707	5,219	5,650	115,576		115,576	1	115,577			1
2	Food Purchase		84,794		84,794		84,794	(1,289)	83,505			2
3	Housekeeping	76,032	10,165		86,197		86,197		86,197			3
4	Laundry	56,199	6,579		62,778		62,778	1	62,779			4
5	Heat and Other Utilities			53,495	53,495		53,495	(1,100)	52,395			5
6	Maintenance	21,331	12,589	18,067	51,987		51,987	1,424	53,411			6
7	Other (specify):* Waste Removal			7,075	7,075		7,075	3	7,078			7
8	TOTAL General Services	258,269	119,346	84,287	461,902		461,902	(960)	460,942			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	796,178	43,187	91,461	930,826		930,826		930,826			10
10a	Therapy	19,056	15,461	138,103	172,620		172,620		172,620			10a
11	Activities	37,591	1,843	3,514	42,948		42,948		42,948			11
12	Social Services	39,572		3,837	43,409		43,409		43,409			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	892,397	60,491	242,415	1,195,303		1,195,303		1,195,303			16
	C. General Administration											
17	Administrative	20,717		64,520	85,237		85,237	1,523	86,760			17
18	Directors Fees											18
19	Professional Services			20,329	20,329		20,329	44,972	65,301			19
20	Dues, Fees, Subscriptions & Promotions			14,363	14,363		14,363	(467)	13,896			20
21	Clerical & General Office Expenses	72,308	17,985	100,100	190,393		190,393	79,921	270,314			21
22	Employee Benefits & Payroll Taxes			189,994	189,994		189,994		189,994			22
23	Inservice Training & Education											23
24	Travel and Seminar			21,508	21,508		21,508	8,479	29,987			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			57,535	57,535		57,535	180	57,715			26
27	Other (specify):*											27
28	TOTAL General Administration	93,025	17,985	468,349	579,359		579,359	134,608	713,967			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,243,691	197,822	795,051	2,236,564		2,236,564	133,648	2,370,212			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**

#0043489

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			49,482	49,482		49,482	2,648	52,130			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,089	122,089		122,089	4,091	126,180			32
33	Real Estate Taxes			49,104	49,104		49,104	38	49,142			33
34	Rent-Facility & Grounds							2,423	2,423			34
35	Rent-Equipment & Vehicles			10,265	10,265		10,265	471	10,736			35
36	Other (specify):*											36
37	TOTAL Ownership			230,940	230,940		230,940	9,671	240,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			1,132	1,132		1,132		1,132			38
39	Ancillary Service Centers		30,860	3,153	34,013		34,013		34,013			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			49,680	49,680		49,680		49,680			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		30,860	53,965	84,825		84,825		84,825			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,243,691	228,682	1,079,956	2,552,329		2,552,329	143,319	2,695,648			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**# **0043489**Report Period Beginning: **1/1/2003**Ending: **12/31/2003****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer-	OHF USE	
			ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,060)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,286)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	1,675	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(183)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(939)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule Vending Income	(792)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (2,585)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	145,904	Var	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 145,904		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 143,319		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ALDERWOOD HEALTH CARE CENTER

ID# 0043489

Report Period Beginning: 1/1/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4	Non-Patient Meals	(1,060)	2 4
5	Telephone, TV & Radio in Resident Rooms	(1,286)	5 5
6			6
7			7
8			8
9	Non-Straightline Depreciation	1,675	30 9
10			10
11			11
12			12
13	Sales Tax	(183)	2 13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25	Fund Raising, Advertising and Promotional	(939)	20 25
26			26
27			27
28			28
29			29
30			30
31			31
32	Vending revenue	(792)	21 32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(2,585)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**# **0043489**

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1	0	0	0	0	0	0	0	0	0	1	1
2	Food Purchase	(1,243)	(46)	0	0	0	0	0	0	0	0	0	(1,289)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	1	0	0	0	0	0	0	0	0	0	1	4
5	Heat and Other Utilities	(1,286)	186	0	0	0	0	0	0	0	0	0	(1,100)	5
6	Maintenance	0	1,424	0	0	0	0	0	0	0	0	0	1,424	6
7	Other (specify):*	0	3	0	0	0	0	0	0	0	0	0	3	7
8	TOTAL General Services	(2,529)	1,569	0	0	0	0	0	0	0	0	0	(960)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	1,523	0	0	0	0	0	0	0	0	0	1,523	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	44,972	0	0	0	0	0	0	0	0	0	44,972	19
20	Fees, Subscriptions & Promotions	(939)	472	0	0	0	0	0	0	0	0	0	(467)	20
21	Clerical & General Office Expenses	(792)	80,713	0	0	0	0	0	0	0	0	0	79,921	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	8,479	0	0	0	0	0	0	0	0	8,479	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	180	0	0	0	0	0	0	0	0	180	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(1,731)	127,680	8,659	0	0	0	0	0	0	0	0	134,608	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(4,260)	129,249	8,659	0	0	0	0	0	0	0	0	133,648	29

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached Organizational Structure Description						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	Dietary	\$	Senior Living Properties, LLC	100%	\$ 1	1	1
2	V	2	Food Purchase		Senior Living Properties, LLC	100%	(46)	(46)	2
3	V	3	Housekeeping		Senior Living Properties, LLC	100%	0		3
4	V	4	Laundry		Senior Living Properties, LLC	100%	1	1	4
5	V	5	Heat and Other Utilities		Senior Living Properties, LLC	100%	186	186	5
6	V	6	Maintenance		Senior Living Properties, LLC	100%	1,424	1,424	6
7	V	7	Waste Removal		Senior Living Properties, LLC	100%	3	3	7
8	V	10	Nursing & Medical Records		Senior Living Properties, LLC	100%	0		8
9	V	10a	Therapy		Senior Living Properties, LLC	100%	0		9
10	V	17	Administrative		Senior Living Properties, LLC	100%	1,523	1,523	10
11	V	19	Professional Services		Senior Living Properties, LLC	100%	44,972	44,972	11
12	V	20	Dues, Fees, Subscriptions & Promotions		Senior Living Properties, LLC	100%	472	472	12
13	V	21	Clerical & General Office Expenses		Senior Living Properties, LLC	100%	80,713	80,713	13
14	Total			\$			\$ 129,249	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	22 Employee Benefits & Payroll Taxes	\$	Senior Living Properties, LLC	100.00%	\$ 0	\$
16	V	24 Travel and Seminar		Senior Living Properties, LLC	100.00%	8,479	8,479
17	V	26 Insurance - Prop Liab Malpractice		Senior Living Properties, LLC	100.00%	180	180
18	V	30 Depreciation		Senior Living Properties, LLC	100.00%	973	973
19	V	32 Interest		Senior Living Properties, LLC	100.00%	4,091	4,091
20	V	33 Real Estate Taxes		Senior Living Properties, LLC	100.00%	38	38
21	V	34 Rent-Facility & Grounds		Senior Living Properties, LLC	100.00%	2,423	2,423
22	V	35 Rent-Equipment & Vehicles		Senior Living Properties, LLC	100.00%	471	471
23	V	36 Loss, Goodwill, & Depreciation		Senior Living Properties, LLC	100.00%	0	
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 16,655	\$ * 16,655

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

Page 7

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER# 0043489Report Period Beginning: 1/1/2003Ending: 12/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Senior Living Properties, LLC
 Street Address 12900 N. Meridian Street, Suite 180
 City / State / Zip Code Carmel, Indiana 46032
 Phone Number (317) 566-1586
 Fax Number (317) 581-9513

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	See attachment	See attachment	See attachment	\$ 16	\$	See attachment	\$ 1	1
2	2	Food Purchase	See attachment	See attachment	See attachment	(3,006)		See attachment	(46)	2
3	3	Housekeeping	See attachment	See attachment	See attachment	0		See attachment	0	3
4	4	Laundry	See attachment	See attachment	See attachment	77		See attachment	1	4
5	5	Heat and Other Utilities	See attachment	See attachment	See attachment	12,972		See attachment	186	5
6	6	Maintenance	See attachment	See attachment	See attachment	110,754		See attachment	1,424	6
7	7	Waste Removal	See attachment	See attachment	See attachment	209		See attachment	3	7
8	10	Nursing & Medical Records	See attachment	See attachment	See attachment	0		See attachment	0	8
9	10a	Therapy	See attachment	See attachment	See attachment	0		See attachment	0	9
10	17	Administrative	See attachment	See attachment	See attachment	99,532		See attachment	1,523	10
11	19	Professional Services	See attachment	See attachment	See attachment	2,548,930		See attachment	44,972	11
12	20	Dues, Fees, Subscriptions & Prom	See attachment	See attachment	See attachment	47,181		See attachment	472	12
13	21	Clerical & General Office Expens	See attachment	See attachment	See attachment	7,140,654		See attachment	80,713	13
14	22	Employee Benefits & Payroll Tax	See attachment	See attachment	See attachment	359		See attachment	0	14
15	24	Travel and Seminar	See attachment	See attachment	See attachment	1,289,367		See attachment	8,479	15
16	26	Insurance - Prop Liab Malpractic	See attachment	See attachment	See attachment	11,789		See attachment	180	16
17	30	Depreciation	See attachment	See attachment	See attachment	63,665		See attachment	973	17
18	32	Interest	See attachment	See attachment	See attachment	212,923		See attachment	4,091	18
19	33	Real Estate Taxes	See attachment	See attachment	See attachment	2,499		See attachment	38	19
20	34	Rent-Facility & Grounds	See attachment	See attachment	See attachment	158,445		See attachment	2,423	20
21	35	Rent-Equipment & Vehicles	See attachment	See attachment	See attachment	30,791		See attachment	471	21
22	36	Loss, Goodwill, & Depreciation	See attachment	See attachment	See attachment	0		See attachment	0	22
23										23
24										24
25	TOTALS					\$ 11,727,157	\$		\$ 145,904	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
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1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

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 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
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B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number ALDERWOOD HEALTH CARE CENTER # 0043489 Report Period Beginning: 1/1/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	GMAC Comm Mort Corp		X	Acquisition	\$ 15,846	2/6/1998	\$ 1,817,718	\$	2/1/2008	0.0681	\$ 122,089	1
2	Complete Care Services		X	Acquisition	\$ 469	2/6/1998	80,430		2/6/2008	N/A - None	N/A - None	2
3	Manager Note		X	Acquisition	\$ 469	2/6/1998	80,430		2/6/2008	N/A - None	N/A - None	3
4	Related Organization		X	Allocated - Schedule VII B							4,091	4
5												5
	Working Capital											
6	Line of Credit		X	Working Capital	None	2/6/1998	Various		Demand	Prime + 2%		6
7												7
8												8
9	TOTAL Facility Related				\$16,784.00		\$ 1,978,578	\$			\$ 126,180	9
	B. Non-Facility Related*											
10	Nonallowable interest		X	See Schedule VI								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,978,578	\$			\$ 126,180	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDERWOOD HEALTH CARE CENTER COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0043489

CONTACT PERSON REGARDING THIS REPORT William H. Keys

TELEPHONE (317) 566-1586 FAX #: (317) 581-9513

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u>06-34-226-014</u>	<u>See Attached</u>	\$ <u>47,906.56</u>	\$ <u>47,906.56</u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u>47,906.56</u>	\$ <u>47,906.56</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ALDERWOOD HEALTH CARE CENTER COUNTY KANE

FACILITY IDPH LICENSE NUMBER 0043489

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () _____ FAX #: () _____

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. _____	_____	\$ _____	\$ _____
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

15,169

B. General Construction Type:

Exterior

BRICK

Frame

WOOD

Number of Stories

1

C.

Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☐

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	131,116	1998	\$ 77,477	1
2					2
3	TOTALS	131,116		\$ 77,477	3

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**# **0043489**

Report Period Beginning:

1/1/2003

Ending:

12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1998	1970	\$ 982,687	\$ 32,756	30	\$ 32,756		\$ 193,807	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Paint Materials		1998		80	15	5	15		80	9
10	Surface Mount		1998		1,022	51	20	51		268	10
11	Bathroom Tile		1998		1,624	81	20	81		432	11
12	Repair Window		1998		2,000	133	15	133		700	12
13	Borders - Remodeling		1998		2,036	340	5	340		2,036	13
14	Copper Piping		1998		2,043	82	25	82		429	14
15	Sprinkler System		1998		2,232	89	25	89		521	15
16	Cove Base		1998		2,289	114	20	114		581	16
17	Remodel Nursing		1998		2,498	167	15	167		889	17
18	Handrails		1998		4,062	271	15	271		1,377	18
19	Water Softener		1998		4,150	415	10	415		2,317	19
20	Paint for Dining Room		1998		4,300	717	5	717		4,300	20
21	Repair Paint Walls		1998		7,400	1,357	5	1,357		7,400	21
22	Tile Kitchen		1998		8,168	408	20	408		2,110	22
23	Remove Wallpaper		1998		9,300	1,550	5	1,550		9,300	23
24	Signage		1998		464	46	10	46		259	24
25	Land Improvements		1999		32,329	2,155	15	2,155		12,752	25
26	Phase IV Paint Halls		1999		8,000	1,600	5	1,600		8,000	26
27	Repair Paint RM 405 & 406		1999		682	136	5	136		670	27
28	Hallway 200 & 400		1999		1,575	105	15	105		516	28
29	Painting Materials for hallway		1999		198	39	5	39		198	29
30	Paint for Halls 100 & 300		1999		461	92	5	92		445	30
31	Building Improvements		2000		2,000	133	15	133		433	31
32	Design for Laundry RM Additions		2000		1,302	87	15	87		333	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37 Sliding Door	2000	\$ 1186	\$ 79	15	\$ 79		\$ 262		37
38 Sprinkler System	2001	6019	241	25	241		683		38
39 Replacement Soffit & Facia	2003	13884	579	10	579		579		39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63 (DON'T ENTER BELOW THIS LINE)									63
64									64
65									65
66									66
67									67
68									68
69									69
70 TOTAL (lines 4 thru 69)		\$ 1,103,991	\$ 43,838		\$ 43,838		\$ 251,677		70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
18									18
19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12F, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
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21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,103,991	\$ 43,838		\$ 43,838	\$	\$ 251,677	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 213,406	\$ 5,507	\$ 7,182	\$ 1,675	Various	\$ 186,176	71
72	Current Year Purchases	4,138	135	135			135	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 217,544	\$ 5,642	\$ 7,317	\$ 1,675		\$ 186,311	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,399,012	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 49,480	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 51,155	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,675	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 437,988	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	<u>N/A</u>			\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,736 Description: Nursing Admin - 198, Central Supply 5,543, Dietary 917, Plant 224, Laundry 405, Admin 2,978, Home Office 471

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>N/A</u>		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					1	Licensed Occupational Therapist	10a, 3	hrs	\$	
2	Licensed Speech and Language Development Therapist	10a, 3	hrs		221	11,046	57	221	11,103	2
3	Licensed Recreational Therapist		hrs		0	0	0			3
4	Licensed Physical Therapist	10a, 3	hrs		1,484	62,575	39	1,484	62,614	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$	3,090	\$ 138,103	\$ 15,461	3,090	\$ 153,564	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (94,190)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	352,475		3
4	Supply Inventory (priced at)	9,669		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 267,954	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	77,477		13
14	Buildings, at Historical Cost	1,095,993		14
15	Leasehold Improvements, at Historical Cost	32,793		15
16	Equipment, at Historical Cost	192,749		16
17	Accumulated Depreciation (book methods)	(437,987)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe			22
23	Other(specify): Intercompany Rec / (Pay)	(3,073,583)		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ (2,112,558)	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ (1,844,604)	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	17,802		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,193		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	49,538		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other accrued expenses	27,431		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 165,964	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 165,964	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (2,010,568)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ (1,844,604)	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (1,590,979)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (1,590,979)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(419,589)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (419,589)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (2,010,568)	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,675,549	1
2	Discounts and Allowances for all Levels	(951,641)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,723,908	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	256,591	6
7	Oxygen	28,161	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 284,752	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	581	13
14	Non-Patient Meals	1,060	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	65,653	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,983	19
20	Radiology and X-Ray	4,837	20
21	Other Medical Services	44,174	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 123,288	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	792	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 792	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,132,740	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	461,902	31
32	Health Care	1,195,303	32
33	General Administration	579,359	33
	B. Capital Expense		
34	Ownership	230,940	34
	C. Ancillary Expense		
35	Special Cost Centers	35,145	35
36	Provider Participation Fee	49,680	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,552,329	40
41	Income before Income Taxes (line 30 minus line 40)**	(419,589)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (419,589)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**# **0043489**Report Period Beginning: **1/1/2003**Ending: **12/31/2003**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	80	192	\$ 5,492	\$ 28.60	1
2	Assistant Director of Nursing					2
3	Registered Nurses	11,487	12,260	288,702	23.55	3
4	Licensed Practical Nurses	4,384	4,693	101,249	21.57	4
5	Nurse Aides & Orderlies	31,838	33,838	383,100	11.32	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,601	1,704	19,056	11.18	8
9	Activity Director	2,285	2,356	28,593	12.14	9
10	Activity Assistants	1,044	1,074	8,998	8.38	10
11	Social Service Workers	2,256	2,617	39,572	15.12	11
12	Dietician	1,992	2,080	28,331	13.62	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	9,585	10,128	76,376	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,076	2,156	21,331	9.89	17
18	Housekeepers	7,333	7,610	76,032	9.99	18
19	Laundry	7,791	8,091	56,199	6.95	19
20	Administrator	640	661	20,717	31.34	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,942	4,289	72,308	16.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,168	1,309	17,635	13.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	89,502	95,058	\$ 1,243,691 *	\$ 13.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	141	\$ 5,650	1, 3	35
36	Medical Director	48	5,500	9, 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	96	8,856	10, 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	62	3,514	11, 3	44
45	Social Service Consultant	63	3,837	12, 3	45
46	Other(specify) Administrator Consultant	2,080	63,336	17, 3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,490	\$ 90,693		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,113	\$ 54,688	10, 3	50
51	Licensed Practical Nurses	230	9,797	10, 3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,343	\$ 64,485		53

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**# **0043489**Report Period Beginning: **1/1/2003**Ending: **12/31/2003****XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			Ownership	Amount	D. Employee Benefits and Payroll Taxes			Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description		Description		Description			
Pearl E. Boulnois	Admin	0%	\$ 20,717	Workers' Compensation Insurance	\$ 55,774	IDPH License Fee	\$	Advertising: Employee Recruitment			
				Unemployment Compensation Insurance	2,662	Health Care Worker Background Check		(Indicate # of checks performed _____)			
				FICA Taxes	95,142						
				Employee Health Insurance	34,506	Dues & Subscriptions	14,363	Advertising & Public Relations			
				Employee Meals	0						
				Illinois Municipal Retirement Fund (IMRF)*	0						
				Other Benefits	1,679						
					0						
				Employee Physicals	231						
					0	Home Office Allocation	472	Less: Public Relations Expense	(0)		
					0	Non-allowable advertising	(939)	Yellow page advertising			
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 20,717					TOTAL (agree to Sch. V, line 20, col. 8)	\$ 13,896		
(List each licensed administrator separately.)											
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)				\$ 189,994			
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
Contract Services: Administrator			\$ 63,336	Description	Line #	Amount	Description	Amount			
Misc. Fees			1184				Out-of-State Travel	\$			
							In-State Travel	18,612			
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 64,520								
(Attach a copy of any management service agreement)							Seminar Expense	785			
C. Professional Services							Business Meals	2,111			
Vendor/Payee	Type		Amount				Home Office Allocation	8,479			
Legal Fees	Various						Entertainment Expense	()			
Patient Litigation	Various						(agree to Sch. V, line 24, col. 8)				
Payroll Processing	Various		1,218				TOTAL	\$ 29,987			
Accounting	Various		14,902								
EDP Services	Various		4,209								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 20,329								

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number **ALDERWOOD HEALTH CARE CENTER**

STATE OF ILLINOIS

0043489

Report Period Beginning:

1/1/2003

Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. 3,543 - Illinois Health Care Assoc.
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 12,171 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES N/A NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 49680
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 1,060
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? N/A
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.